



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date OCT 3 2000
From *Michael M. Angelo*
for June Gibbs Brown
Inspector General

Subject Follow-Up Audit of Medicare Clinical Laboratory Tests Performed by Independent Clinical and Physician Laboratories (A-01-99-00522)

To Michael Hash
Acting Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Follow-Up Audit of Medicare Clinical Laboratory Tests Performed by Independent Clinical and Physician Laboratories." The objective of the audit was to determine the adequacy of procedures and controls (including edits) used by Medicare carriers to process payments for clinical laboratory tests performed by independent clinical and physician laboratories. The audit also followed-up on the extent and effectiveness of corrective actions taken by the Health Care Financing Administration (HCFA) to address the recommendations in our prior review.

Our prior audit report, issued on November 21, 1997 under A-01-96-00509, showed that Medicare carriers overpaid independent clinical and physician laboratories about \$50.2 million for chemistry, hematology, and urinalysis tests during the 2-year period ended June 30, 1995. For the same period, an additional \$30.8 million could have been saved if policies had been adopted by HCFA to preclude payment for additional hematology indices. In its response to our prior report, HCFA agreed with our conclusions and indicated that the codes for additional hematology indices were not valid for Medicare reimbursement and were to be removed from the Medicare fee schedules.

Our current audit showed that carriers did not always have adequate procedures and controls (including edits) to detect and prevent inappropriate payment for laboratory tests. Contrary to applicable laws, regulations, guidelines, and carrier reimbursement policies, carriers continued to reimburse providers for claims involving unbundled and/or duplicate chemistry, hematology, and urinalysis tests that should have been grouped together and paid at a lesser amount. Carriers also reimbursed providers for claims involving additional hematology indices that were no longer valid codes. While inappropriate payments continued, the number of these inappropriate payments significantly decreased. We estimate that, for the 2 1/2-year period from July 1, 1995 through December 31, 1997, carriers nationwide overpaid independent clinical and physician laboratories about \$31.2 million for chemistry, hematology and urinalysis tests, and additional hematology indices. We recommend that HCFA:

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- Direct carriers to recover the estimated \$31.2 million in overpayments made to providers for unbundled and/or duplicate chemistry, hematology, and urinalysis tests for the period July 1, 1995 through December 31, 1997.
- Ensure that correct coding initiative (CCI) edits are implemented correctly and the 81015/81003 combination is correctly added to the edits.
- Ensure that edits for local medical review policies and for exact code duplicates are implemented correctly and do not conflict with CCI initiatives.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you should have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-99-00522 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FOLLOW-UP AUDIT OF MEDICARE
CLINICAL LABORATORY TESTS
PERFORMED BY INDEPENDENT
CLINICAL AND PHYSICIAN
LABORATORIES**



JUNE GIBBS BROWN
Inspector General

OCTOBER 2000
A-01-99-00522

NOTICES

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In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.



EXECUTIVE SUMMARY

BACKGROUND

This report presents the results of our nationwide audit of clinical laboratory services performed by independent clinical and physician laboratories. The audit follows up on the Health Care Financing Administration's (HCFA) efforts to initiate corrective action regarding unbundled and duplicate charges involving chemistry, hematology, and urinalysis tests and additional hematology indices. These issues were addressed in our prior report entitled, "Review of Clinical Laboratory Tests Performed by Independent Laboratories and Physicians" (A-01-96-00509), issued on November 21, 1997.

OBJECTIVE

The objective of this audit was to determine the adequacy of procedures and controls (including edits) used by Medicare carriers to process payments for clinical laboratory tests performed by independent clinical and physician laboratories. The audit was designed to determine whether certain chemistry, hematology, and urinalysis tests were appropriately grouped together and/or not duplicated for Medicare payment purposes. The audit was a follow-up on the extent and effectiveness of corrective actions taken by HCFA to address the recommendations in our prior review.

SUMMARY OF FINDINGS

Our audit showed that carriers did not always have adequate procedures and controls (including edits) to detect and prevent inappropriate payment for clinical laboratory tests. Contrary to applicable laws, regulations, guidelines, and carrier reimbursement policies, carriers reimbursed providers for claims involving unbundled and/or duplicate chemistry, hematology, and urinalysis tests that should have been grouped together and paid at a lesser amount. Carriers also reimbursed providers for claims involving additional hematology indices that were no longer valid codes. As a result, we estimate that, for the 2 1/2-year period from July 1, 1995 through December 31, 1997, carriers nationwide overpaid independent clinical and physician laboratories about \$31.2 million for chemistry, hematology (including additional indices), and urinalysis tests. Because of the correct coding initiative (CCI) edits, this amount decreased significantly from our prior audit's finding which reported \$50.2 million in overpayments and \$30.8 million in potential cost savings for additional hematology indices for the 2-year period ended June 30, 1995.

RECOMMENDATIONS

We recommend that HCFA:

- Direct carriers to recover the estimated \$31.2 million in overpayments made to providers for reimbursement of unbundled and/or duplicate chemistry,

hematology, and urinalysis tests for the period July 1, 1995 through December 31, 1997.

- Ensure the CCI edits are implemented correctly and the 81015/81003 combination is correctly added to the edits.
- Ensure that edits for local medical review policies and for exact code duplicates are implemented correctly and do not conflict with CCI initiatives.

HCFA COMMENTS

In its written comments on our draft report (see APPENDIX E), HCFA concurred with our recommendations and indicated they will ensure that Medicare contractors will make the appropriate recovery efforts.

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INTRODUCTION

BACKGROUND

Clinical laboratory services which are frequently performed on automated equipment include chemistry, hematology, and urinalysis tests. Chemistry tests involve the measurement of various chemical levels in the blood while hematology tests are performed to count and measure blood cells and their content. Urinalysis tests involve the measurement of certain components of the sample, and may also include a microscopic examination. Depending on the number of tests performed on behalf of a beneficiary on the same day by the same provider, the services may be billed to Medicare on one or more claims.

For reimbursement purposes, clinical laboratory providers were required to group chemistry tests that were performed on automated equipment into a chemistry profile and to bill the grouped tests under a profile code. Chemistry tests are also combined under problem-oriented classifications (referred to as organ panels). Organ panels were developed for coding purposes and were to be used when all of the component tests are performed. Many of the component tests of organ panels are automated chemistry profile tests.

Hematology tests grouped and performed on an automated basis are classified as profiles. Automated profiles include hematology component tests such as hematocrit, hemoglobin, red and white blood cell counts, platelet count, differential white blood cell counts, and a number of indices. Indices are measurements and ratios calculated from the results of hematology tests. Examples of indices performed as part of the hematology profile are red blood cell width, red blood cell volume, and platelet volume.

A complete urinalysis includes testing for components and a microscopic examination. However, providers can perform different levels of urinalysis by testing for only those components requested. Recent coding initiatives prompted the use of computer edits to ensure that hematology and urinalysis tests are properly billed and reimbursed.

Part B of Title XVIII of the Social Security Act (Act), as amended, covers clinical laboratory services performed for outpatients at hospitals, physician's practices, or independent clinical laboratories. While claims for clinical laboratory tests performed on an outpatient hospital basis are processed by Medicare fiscal intermediaries, claims for clinical laboratory services provided by independent clinical laboratories and physicians are processed for payment by Medicare carriers. Medicare pays 100 percent of the fee schedule amount or actual charge for the clinical laboratory service (whichever is lower) provided that the service is reasonable and necessary for the diagnosis or treatment of an illness or injury.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of the audit was to determine the adequacy of procedures and controls (including edits) used by carriers to process payments for clinical laboratory tests performed by independent clinical and physician laboratories. Specifically, the audit was designed to determine whether certain chemistry, hematology (including indices), and urinalysis tests were appropriately grouped together (bundled into a panel or profile) and not duplicated for Medicare payment purposes.

In this regard, we are following-up on the extent and effectiveness of corrective actions taken by HCFA to address the results of our prior review entitled, "Review of Clinical Laboratory Tests Performed by Independent and Physician Laboratories" (A-01-96-00509). Specifically, we addressed HCFA's corrective actions related to our recommendations regarding unbundled and/or duplicate chemistry, hematology, and urinalysis tests and eliminating separate reimbursement for additional hematology indices.

To accomplish our objective, we reviewed instances of potential overpayments for claims paid during the period July 1, 1995 through December 31, 1997. Instances of potential overpayments occur when a carrier pays an independent clinical or physician laboratory for unbundled or duplicate tests provided on behalf of a beneficiary on the same day. To obtain a population of potential overpayments for our review, we extracted payments applicable to selected chemistry, hematology, and urinalysis tests from HCFA's Clinical Laboratory Standard Analytical File, for the period of the audit. Using a series of computer applications applied to our extract of the Clinical Laboratory file, we identified those instances in which selected tests could have been grouped but were billed and paid separately or with duplication, and those instances in which additional hematology indices were billed and paid. Our extract and match resulted in identifying a population of 6,920,691 instances of potential overpayments.

In order to confirm that all the payments in the population that we developed through extract and match were potentially overpaid, we compared the payment data to source documents (i.e., billings and remittance advices) for 720 statistically selected instances of potential overpayments from 8 statistically selected carriers. For each sample claim selected, we determined whether an overpayment actually occurred. We analyzed each claim by comparing amounts actually paid against amounts that should have been paid based on the correct billing codes and appropriate Medicare fee schedule amount. The resulting difference was identified as an overpayment.

We projected the total dollar amount of overpayments using a variable sample appraisal methodology. Our estimate was based on a statistical projection of the results of our sample and extrapolated to the universe of claims containing instances of potential overpayments. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A.

The chemistry, hematology, and urinalysis tests that were part of our review are listed in the "Physicians' Current Procedural Terminology" (CPT) manual and contained in APPENDIX B.

APPENDIX C provides detailed information on the scope of our review at each of the eight carriers.

Our review of the internal controls at each carrier was limited to an evaluation of that part of the claims processing function that related to the processing of claims for clinical laboratory services. Specifically, we reviewed each of the eight carriers' policies, procedures, and instructions to providers related to the billing of clinical laboratory services. We also reviewed carrier documentation relating to manual or automated bundling and duplicate claim detection edits for chemistry, hematology, and urinalysis tests. We did not assess the completeness of HCFA's data files nor did we evaluate the adequacy of the input controls.

We conducted our nationwide audit in accordance with generally accepted government auditing standards. The audit was conducted at the HCFA central office and the Office of Inspector General's regional Office of Audit Services in Boston, Massachusetts. We also contacted the eight carriers selected in our sample to obtain source documentation used in our review.

FINDINGS AND RECOMMENDATIONS

Our audit showed that carriers did not always have adequate procedures and controls (including edits) to detect and prevent inappropriate payment for clinical laboratory tests. Contrary to applicable laws, regulations, guidelines and carrier reimbursement policies, carriers reimbursed providers for claims involving unbundled and/or duplicate chemistry, hematology, and urinalysis tests that should have been grouped together and paid at a lesser amount. Carriers also reimbursed providers for claims involving additional hematology indices that were no longer valid codes. As a result, we estimate that, for the 2 1/2-year period from July 1, 1995 through December 31, 1997, carriers nationwide overpaid independent clinical and physician laboratories about \$31.2 million for chemistry, hematology (including additional indices), and urinalysis tests. Because of the implementation of computerized edits, this amount decreased significantly from our prior audit's finding which reported \$50.2 million in overpayments and \$30.8 million in potential cost savings for hematology indices for the 2-year period ended June 30, 1995.

CLINICAL LABORATORY SERVICES REIMBURSEMENT REQUIREMENTS

In regard to establishing fee schedules, section 1833(h)(1)(A) of the Act authorized the Secretary to establish fee schedules for clinical diagnostic laboratory tests provided to Medicare outpatients. Section 1833(h)(2)(A)(i) authorized the Secretary to make "...adjustments as the Secretary determines are justified by technological changes...." While this section did not specifically address grouping of automated clinical laboratory tests into profiles, bundling rules were addressed in section 5114.1.L of the Medicare Carriers Manual (MCM).

Medicare claims for clinical laboratory services are reimbursed based on fee schedules and are subject to the guidelines published by HCFA in its MCM. Medicare pays the lesser of the national limit as published by HCFA annually, an individual carrier fee schedule amount, or the actual charge for the service providing that the service is reasonable and necessary.

Section 5114 of the MCM states that:

"This section sets out payment rules for diagnostic laboratory services, i.e., (1) outpatient clinical diagnostic laboratory tests subject to the fee schedule, and (2) other diagnostic laboratory tests...."

Section 5114.1L.1 continues on to list those tests which can be and are frequently performed as profiles on automated multichannel equipment. Section 5114.1L.2 also directs carriers to make payment at the lesser amount for the profile if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the profile that includes these tests.

Based on the above criteria, Medicare providers were required during our audit period to group outpatient clinical laboratory tests into the applicable profile codes when the tests are performed for the same patient on the same date of service.

Section 7103.1B of the MCM discusses duplicate payments and provides that if an overpayment to a physician is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the physician does not have a reasonable basis for assuming that the total payment he received was correct and thus should have questioned it. The physician is, therefore, at fault and liable for the overpayment.

CORRECT CODING INITIATIVE'S EFFECT ON CLINICAL LABORATORY SERVICES

The MCM directs carriers how to make payment for tests which are performed on automated multichannel equipment; requires physicians to question payments they receive for overlapping or duplicate bills; and instructs carriers to implement the CCI. The CCI contains a list of edits that determine how medical procedures should be reimbursed, including most of the clinical laboratory procedure codes in the scope of our audit. The CCI edits became mandatory on January 1, 1996 and were a factor in the decrease of overpayments identified in our review.

Through the CCI edits, HCFA set out to control the inappropriate coding of Part B services. For purposes of the CCI edits, most of the chemistry, hematology, and urinalysis clinical laboratory procedure codes that we have included in our laboratory reviews (APPENDIX B) were considered to be mutually exclusive of one another or part of a comprehensive/component relationship. Section 4630 of the MCM requires that the carriers use the CCI edits without altering them. Edits other than the CCI edits must continue if instructed by HCFA, and carriers are allowed to edit for local medical review policies that are not covered by the CCI edits.

IMPACT OF CORRECTIVE ACTIONS

The results of our review show a steady decrease in clinical laboratory test overpayments from July 1, 1995 to December 31, 1997. By the last day of December 1997, there were significantly less overpayments than we found in our prior review. The computerized edits required by the CCI were responsible for these large decreases. However, our findings show more work is needed to correct the remaining problems and to collect the resulting overpayments. The remaining problems deal primarily with the CCI edits as well as other corrective actions that were not implemented in a timely manner. The following presents the results of our audit in each of the three categories of tests reviewed.

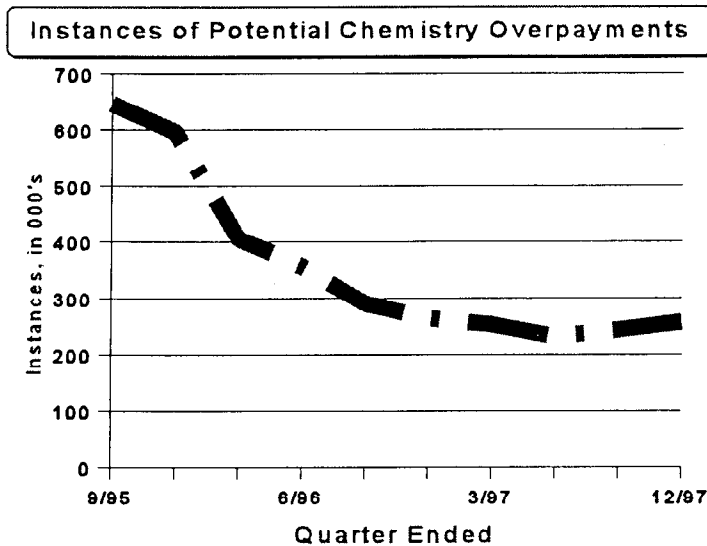
Chemistry Tests

The audit showed that, of 240 sample items related to chemistry claims containing potential unbundling or duplication, 150 were found to be overpaid (APPENDIX D). These items resulted in overpayments amounting to \$1,303. Extrapolating the results of our statistical sample to our population of potential chemistry test overpayments, we estimate that nationwide, carriers overpaid independent clinical and physician laboratories about \$10.8 million for unbundled or duplicated chemistry tests during our 2 1/2-year audit period.

In contrast to our prior 2-year audit period, this represented a significant decrease in estimated potential chemistry overpayments previously reported at \$25.2 million. In this regard, the number of potential instances of overpayments between the prior audit period and the current audit period decreased from 7,969,060 to 3,544,247. Our sample results from the current period continue to reflect this downward trend. The following schedule shows how these instances of potential overpayments were decreasing in our population during our current audit period.

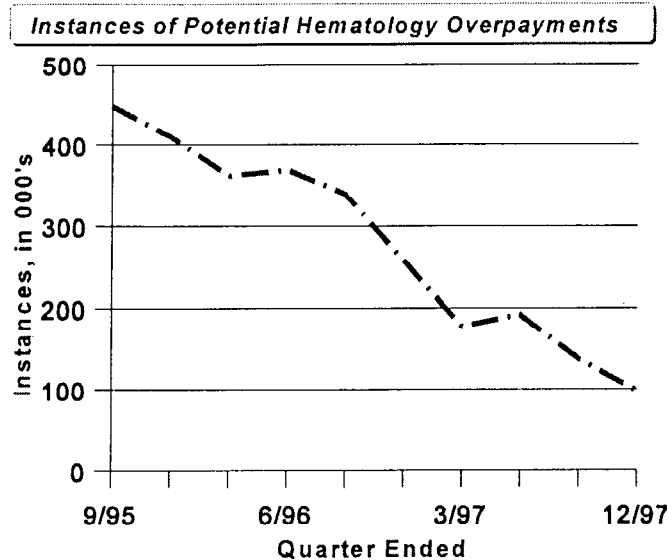
Although the overpayments were trending downward, seven of the eight carriers reviewed did not implement HCFA's corrective actions in a timely manner to ensure chemistry tests were properly grouped together for reimbursement purposes. Some of the overpayments we found would have been prevented by the CCI edits. Also, although HCFA mandated that all carriers adopt policies to group three previously optional chemistry tests, we found several instances

where carriers' edits did not preclude payment when these tests were billed individually. Further, a hepatic function panel, which contains five automated multichannel chemistry tests, was not always treated as automated tests that were subject to being grouped together for reimbursement purposes.



Hematology Tests And Additional Hematology Indices

For hematology tests, we verified that 230 of 240 sample items were overpayments (APPENDIX D). These items resulted in overpayments amounting to \$1,549. Extrapolating the results of our statistical sample to our population of potential hematology overpayments, we estimate that nationwide, carriers overpaid independent clinical and physician laboratories about \$18.4 million for unbundled and duplicated hematology tests during our 2 1/2-year audit period. In contrast to our prior 2-year audit period, this represented a significant decrease in estimated potential hematology and additional indices overpayments previously reported at \$23.1 million and cost savings previously reported at \$30.8 million. In this regard, the number of potential instances of overpayments between the prior audit period and current audit period decreased from 6,509,720 to 2,791,926. Our sample results from the current audit period continue to reflect this downward trend. The following schedule shows how these instances of potential overpayments were decreasing in our population during our current audit period.



Of the errors found in our hematology sample, 115 were the result of additional hematology indices. The remaining errors were situations that were listed as CCI edits or should have been prevented by edits outside of the CCI. For example, 58 of the errors were from exact code duplicates (same beneficiary, provider, date of service, and procedure code).

Our audit work showed that the procedure codes for additional hematology indices were simultaneously eliminated from the CPT manual and HCFA's Medicare clinical laboratory fee schedules, effective January 1999. However, we believe that the payments for additional hematology indices during our audit period were inappropriate for the reasons identified during our various audits of this issue. Also, in our current audit, we determined that six of the eight carriers we sampled had local medical review policies to deny payment of additional hematology indices either with pre-payment edits or post-payment reviews.

Despite the policies that were implemented to deny payment of additional hematology indices, 115 out of the 240 hematology sample items contained payments for these services. These 115 items were at 4 carriers that had policies to deny payment of additional hematology indices. The other 4 carriers did not have payments for additional hematology indices in the universe of 2,791,926 potential hematology overpayments. We believe that the payments for additional hematology indices represent overpayments by the Medicare program because they were for services that were inappropriate for Medicare reimbursement.

Our conclusion that these services represent overpayments was based on various factors identified during our prior and current audits of clinical laboratory services as follows:

- Many Medicare contractors had developed policies to either deny separate payment for additional hematology indices or only pay based on documented medical need. This was especially evident among Medicare carriers, as our survey of all carriers nationwide determined that 38 of 52 carriers had such policies. Our follow-up with eight fiscal

intermediaries included in our prior audit of hospital outpatient laboratories showed that four either had non-payment policies for additional hematology indices in effect or have implemented such policies since the time of our last audit. These policies were usually developed after studies by the contractors' advisory committees determined that additional hematology indices were seldom clinically useful or were merely a by-product of analysis performed on automated equipment which performs the hematology tests and calculates and measures all indices simultaneously.

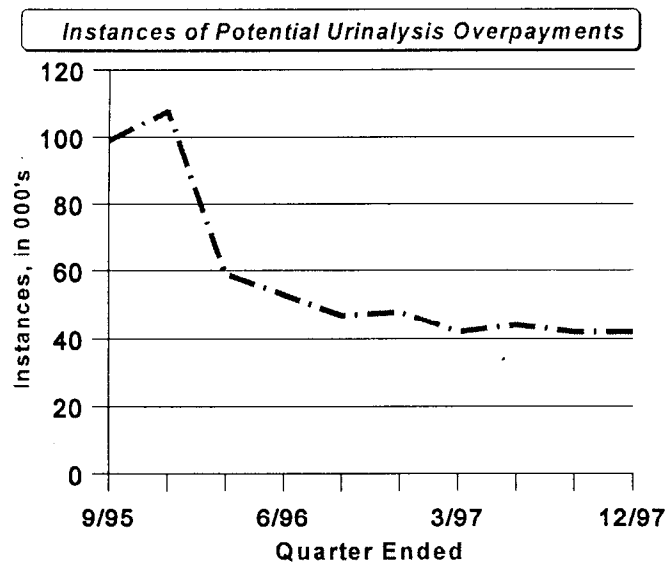
- In our last review, we noted that, overall, laboratories did not provide the opportunity for the physicians to order additional indices separately. Laboratory order forms did not provide a separate space or line on the form to enable the physicians to order the additional indices, if necessary. Instead, the physicians were provided the additional indices and the laboratories billed separately even though the physicians had not indicated their need for the additional indices.
- The prior audit of hospital outpatient laboratories showed that only 27 percent of the hospital outpatient department laboratories accounted for 75 percent of the additional hematology indices billed. For our current audit period, we determined that only 23 percent of the hospital outpatient department laboratories accounted for 80 percent of the billed services indicating that the practice was even more concentrated among relatively few providers. Accordingly, we believe that billings for additional hematology indices were driven by the billing practices of certain providers rather than medical need.

In summary, we believe that the results described above from our prior and current audits provide significant evidence to support our position that additional hematology indices were merely by-products of the automated process used to perform hematology tests, were not used by most physicians in treating their patients, and were the result of a billing practice used by certain providers to maximize revenue. The HCFA concurred with our prior review's recommendation to eliminate reimbursement for additional indices. In their response to our report, HCFA stated that: "Based on the report finding that additional hemogram indices (CPT codes 85029 and 85030) are not test results but rather, calculations using the results of tests that were already billed, we will revise our coding instructions to indicate that these codes are not valid for Medicare and we will remove them from our fee schedule." The actions taken by HCFA to eliminate the additional hematology indices from the Medicare fee schedules further substantiate our position that additional hematology indices were not a routine medical service that should have been billed to Medicare. The HCFA's action eliminated the problem for future periods. However, we believe that HCFA should take action to recover the overpayments identified by our current review for the period July 1, 1995 through December 31, 1997.

Urinalysis Tests

Our review showed that 233 of 240 of our urinalysis sample items were overpayments resulting from duplication (APPENDIX D). These items resulted in overpayments amounting to \$741.56. Extrapolating the results of our statistical sample to our population of potential urinalysis overpayments, we estimate that nationwide, carriers overpaid independent clinical and physician laboratories about \$2 million for duplicated urinalysis tests during our 2 1/2-year audit period. In contrast to our prior 2-year audit period, this represents a decrease in estimated potential urinalysis overpayments previously reported at \$1.9 million. In this regard, the number of potential instances of overpayments between the prior period and current audit decreased from 619,800 to 584,518. Our sample results from the current period continue to reflect this downward trend.

The following schedule shows how these instances were decreasing in our population during our current audit period.



The majority of the urinalysis errors (155 items) were the result of a mutually exclusive code combination that was mistakenly left out of the CCI edits (CPT 81015 with CPT 81003). The medical director at the contractor responsible for compiling the CCI edits agreed that this combination should not be billed on the same day for the same beneficiary and a new edit should be added to the claims processing system. The remaining errors were situations that were listed as CCI edits or should have been prevented by edits outside of the CCI. For example, 40 of the errors were from exact code duplicates (same beneficiary, provider, date of service, and procedure code).

RECOMMENDATIONS

We recommend that HCFA:

- Direct carriers to recover the estimated \$31.2 million in overpayments made to providers for reimbursement of unbundled and/or duplicate chemistry, hematology, and urinalysis tests for the period July 1, 1995 through December 31, 1997. We will make available to HCFA our computer files identifying the overpayments by provider for use in these recovery efforts. In addition, HCFA should coordinate all recovery efforts with applicable investigative agencies.
- Ensure the CCI edits are implemented correctly and the 81015/81003 combination is correctly added to the edits.
- Ensure that edits for local medical review policies and for exact code duplicates are implemented correctly and do not conflict with CCI initiatives.

HCFA COMMENTS

In its written comments to our draft report (see APPENDIX E), HCFA concurred with our recommendations. The HCFA also indicated that once they receive the computer files identifying the potential overpayments, they will ensure the Medicare contractors begin appropriate recovery efforts.

APPENDICES

SAMPLE METHODOLOGY

This report covers Medicare payments for clinical laboratory services provided from July 1, 1995 to December 31, 1997.

To obtain a population of potential overpayments, we extracted applicable payments for selected chemistry, hematology, and urinalysis tests from HCFA's Clinical Laboratory Standard Analytical File for the period of the audit. The extract included all claims containing:

- chemistry profiles and profile tests for chemistry procedure codes listed in the CPT manual (APPENDIX B);
- hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT manual (APPENDIX B);
- urinalysis component tests listed in the CPT manual (APPENDIX B).

We then performed a series of computer applications to identify all records for the same individual for the same date of service with HCFA's Common Procedure Coding System (HCPCS) line item charges for:

- more than one chemistry profile; a chemistry profile and at least one individual profile test; or two or more profile tests;
- more than one automated hematology profile under different profile codes; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or additional indices and a profile; and
- a complete urinalysis test which includes microscopy; a urinalysis without microscopy; or a microscopic only.

Each instance is a potential payment error in which the carriers paid providers for clinical laboratory tests (on behalf of the same beneficiary on the same date of service) which were billed individually instead of as part of a group, or were duplicates of each other. An example of an overpayment follows.

SAMPLE METHODOLOGY

Example of an Overpayment

Test Code	Test Name	Units	Paid Amount
Individual Test Codes			
82040	Albumin (individual chemistry test)	1	\$7.00
82465	Cholesterol (individual chemistry test)	1	\$6.47
84478	Triglycerides (individual chemistry test)	1	\$8.54
Total Paid			\$22.01

Profile Test Code/Internal Billing Code

80003/ ATP03	for any 3 clinical chemistry automated, multichannel panel tests	1	\$10.85
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Difference in Amounts Paid is an Overpayment: \$11.16

We extended our computer applications to determine the instances of potential overpayments at each Medicare carrier nationwide. We then statistically selected eight carriers for audit by applying a multistage sample that weighted the carriers by instances of potential overpayment.

On a statistically selected basis, we examined 720 instances of potential overpayments involving claims for clinical laboratory services in the 8 Medicare carriers selected for audit. The instances of potential overpayments were stratified into the clinical laboratory service categories of chemistry, hematology, and urinalysis tests. For each category, 240 instances of potential overpayment were sampled (30 at each carrier times the 8 carriers selected). For each sampled instance, we requested and reviewed supporting documentation from the carrier consisting of copies of physician or independent laboratory claims and related paid claims history. Our review disclosed 613 potential overpayments out of the 720 instances examined.

To quantify the potential overpayments for unbundled chemistry profile tests, duplicate hematology profile tests (and additional indices), and unbundled or duplicate urinalysis tests, we performed a multistage sample appraisal weighted by the number of instances of potential overpayments at each carrier (APPENDIX D).

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

<u>Chemistry Profile CPT Code Description</u>	<u>CPT Code</u>
1 or 2 clinical chemistry automated multichannel test(s)	80002
3 clinical chemistry automated multichannel tests	80003
4 clinical chemistry automated multichannel tests	80004
5 clinical chemistry automated multichannel tests	80005
6 clinical chemistry automated multichannel tests	80006
7 clinical chemistry automated multichannel tests	80007
8 clinical chemistry automated multichannel tests	80008
9 clinical chemistry automated multichannel tests	80009
10 clinical chemistry automated multichannel tests	80010
11 clinical chemistry automated multichannel tests	80011
12 clinical chemistry automated multichannel tests	80012
13-16 clinical chemistry automated multichannel tests	80016
17-18 clinical chemistry automated multichannel tests	80018
19 or more clinical chemistry automated multichannel tests	80019
20 clinical chemistry automated multichannel tests	G0058
21 clinical chemistry automated multichannel tests	G0059
22 clinical chemistry automated multichannel tests	G0060

<u>Chemistry Profile Test CPT Code Description</u>	<u>CPT Code</u>
Alanine Aminotransferase (ALT, SGPT)	84460
Albumin	82040
Alkaline phosphatase	84075
Aspartate aminotransferase (AST, SGOT)	84450
Bilirubin, total or direct	82250
Bilirubin, total and direct	82251
Carbon dioxide	82374
Calcium	82310
Chloride	82435
Creatinine	82565
Cholesterol	82465
Glucose	82947
Creatine kinase (CK, CPK)	82550
GammaGlutamylTransferase (GGT)	82977
Lactate dehydrogenase (LDH, LD)	83615
Phosphorus	84100
Potassium	84132
Protein, total	84155

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

Sodium	84295
Triglycerides	84478
Urea nitrogen (BUN)	84520
Uric Acid	84550

<u>Hematology Component Test CPT Code Description</u>	<u>CPT Codes</u>
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Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Colorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC Count	85007
Platelet Count (Electronic Technique)	85595

<u>Additional Hematology Component Tests - Indices</u>	<u>CPT Codes</u>
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Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

<u>Hematology Profile CPT Code Description</u>	<u>CPT Codes</u>
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Hemogram (RBC, WBC, Hbg, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram and Platelet and Complete Automated Differential	85025
Hemogram and Platelet	85027

<u>Urinalysis and Component Test CPT Code Description</u>	<u>CPT Codes</u>
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Urinalysis	81000
Urinalysis, automated	81001
Urinalysis without microscopy	81002,81003
Urinalysis microscopic only	81015

DETAILED SCOPE OF AUDIT

The extract from the Clinical Laboratory Standard Analytical File totaled 6,920,691 instances of potential overpayment. This total reflects an unduplicated count since a claim can contain more than one type of potential overpayment. Our computer program stratified each potential overpayment into one of three error categories by carrier. The first category consisted of 3,544,247 instances of potentially unbundled chemistry profile tests. The second category consisted of 2,791,926 instances of potentially duplicate hematology tests. The third category consisted of 584,518 instances with potentially duplicate urinalysis profiles and tests.

CARRIER	INSTANCES OF POTENTIAL OVERPAYMENT
Nationwide Insurance - West Virginia	15,535
Adminastar Federal (formerly Blue Shield) - Indiana	58,758
Triple S (formerly Blue Shield) - Puerto Rico	197,417
Trailblazers (formerly Blue Shield) - Texas	873,428
Arkansas Blue Cross Blue Shield (formerly Aetna) - Oklahoma	62,648
Empire Medicare Services (formerly Blue Shield) - New Jersey	449,394
Transamerica Occidental Life Insurance - California	1,209,213
Arkansas Blue Cross Blue Shield (formerly General American) - Missouri	50,326
Total Sample	<u>2,916,719</u>
Total for All Carriers	<u>6,920,691</u>

Our random selection of these eight carriers resulted in a sample that is representative of the population.

ESTIMATE OF POTENTIAL OVERPAYMENTS

CARRIER	CHEMISTRY		HEMATOLOGY		URINALYSIS		TOTAL	
	SAMPLE SIZE	SAMPLE ERROR	SAMPLE SIZE	SAMPLE ERROR	SAMPLE SIZE	SAMPLE ERROR	SAMPLE SIZE	SAMPLE ERROR
16510-WV	30	29	30	26	30	29	90	84
00630-IN	30	10	30	29	30	28	90	67
00973-PR	30	10	30	30	30	29	90	69
00900-TX	30	28	30	30	30	30	90	88
01370-OK	30	30	30	29	30	30	90	89
00860-NJ	30	0	30	29	30	30	90	59
02050-CA	30	18	30	30	30	30	90	78
11260-MO	30	25	30	27	30	27	90	79
TOTALS	240	150	240	230	240	233	720	613

TOTAL ESTIMATE OF POTENTIAL OVERPAYMENTS

STRATUM	POINT ESTIMATE	LOWER LIMIT	UPPER LIMIT	PRECISION* (+/- percent)
CHEMISTRY	\$10,825,128	\$ 5,222,138	\$16,428,117	51.76%
HEMATOLOGY	\$18,360,933	\$12,193,252	\$24,528,614	33.59%
URINALYSIS	\$ 2,027,056	\$ 779,728	\$ 3,274,384	61.53%
TOTAL ESTIMATED OVERPAYMENT	\$31,213,117	\$22,417,745	\$40,008,488	28.18%

Based on our sample appraisal methodology, we are 90 percent confident that the dollar value of errors is between \$22,417,745 and \$40,008,488. Accordingly, we are 95 percent confident that the dollar value of errors is \$22,417,745 or more.

*Based on 90 percent confidence level



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

RECEIVED

DATE: JUL 20 2000

2000 JUL 24 PM 2:38

TO: June Gibbs Brown
Inspector GeneralOFFICE OF INSPECTOR
GENERALFROM: Nancy-Ann Min DeParle
Administrator

The Administrator
Washington, D.C. 20201

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EI	<input type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
OCIG	<input type="checkbox"/>
ExecSec	<input type="checkbox"/>
Date Sent	7/27/00

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Followup Audit of Medicare Clinical Laboratory Tests Performed by Independent Clinical and Physician Laboratories," (A-01-99-00522)

Thank you for the opportunity to comment on the above-referenced report. Medicare spent \$3.5 billion on clinical laboratory services in 1998. I am pleased with our success in reducing the number of instances in which hematology indices were paid improperly roughly in half - from more than \$25 million a year (\$50.2 million over 2 years) to about \$12 million a year (\$30.8 million over 2 1/2 years). The Health Care Financing Administration (HCFA) has already taken steps that will continue to improve our performance in this area. The claims included in this study were from 1995 through 1997. In January 1999, HCFA removed codes 85029 and 85030 from the Medicare fee schedule. We are confident that a contemporary study would find that this resulted in a dramatic reduction or elimination of improperly paid hematology indices.

Specific efforts taken by our Medicare contractors to effectuate the above reduction are just part of our broader strategy to protect Medicare today and into the future. Since 1993, the Clinton Administration has done more than any previous administration to fight waste, fraud, and abuse of the Medicare program, which pays more than \$200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments, and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered nearly \$500 million as a result of health-care prosecutions. Medicare has also reduced its improper payment rate sharply from 14 percent 4 years ago to less than 8 percent last year, and HCFA is committed to achieving further reductions in the future.

HCFA is constantly acting to ensure that Medicare pays appropriately. The correct coding initiative (CCI) includes over 100,000 procedure edits. On January 1, 1996, Medicare carriers began implementing CCI edits. As of December 31, 1999, the CCI has prevented approximately \$1 billion from being erroneously paid out of the Medicare Trust Fund.

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We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised. We concur with the OIG's recommendations, and our specific comments follow.

OIG Recommendation

HCFA should direct carriers to recover the estimated \$31.2 million in overpayments made to providers for reimbursement of unbundled and/or duplicative chemistry, hematology, and urinalysis tests for the period of July 1, 1995, through December 31, 1997. We will make available to HCFA our computer files identifying overpayments by provider for use in these recovery efforts. In addition, HCFA should coordinate all recovery efforts with applicable investigative agencies.

HCFA Response

We concur. However, while we agree with the OIG's findings, neither HCFA nor the OIG can determine the exact amount of the overpayment without additional review. We look forward to receiving the computer files identifying the potential overpayments by provider so that HCFA may begin this review. Upon receipt of those files, we will ensure that the fiscal intermediaries (FIs) begin appropriate recovery efforts. We will forward a copy of the draft audit report to the appropriate regional office (RO) with instructions to contact the OIG auditor for further instructions.

We also note that the results of prior audits were provided to the Department of Justice (DOJ) for additional investigation. Since it is the RO's responsibility to monitor the FI's role in the recoupment of overpayments, we will advise the RO to coordinate its efforts with the DOJ and the OIG's Office of Investigation.

OIG Recommendation

Ensure the CCI edits are implemented correctly and the 81015/81003 combination is correctly added to the edits.

HCFA Response

This was accomplished by the January 1999 action to delete the codes. No further action on this recommendation is required.

OIG Recommendation

Ensure that edits for local medical review policies and for exact code duplicates are implemented correctly and do not conflict with CCI initiatives.

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HCFA Response

Prior to January 1999, it was possible for laboratories to bill for additional hematology indices billing CPT codes 85029 and 85030. For that reason, the majority of Medicare contractors elected to develop Local Medical Review Policies (LMRPs) to either deny separate payment for additional indices or only pay based on demonstrated medical necessity. In January 1999, HCFA determined that additional indices were not tests, but rather calculations from tests already billed. At that time, these codes were removed from the Medicare fee schedule, and LMRPs became invalid, since edits were automatically implemented to deny these codes. In other words, the problem was corrected with the HCFA January 1999 action to delete the codes. No further action is indicated on this recommendation.